Dr. Kneisley 14

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (W)

10385

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 5 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 930 The Terrace
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: Miss Florence Baker

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Single

6.(b) Name of husband or wife: –

6.(c) If alive, give age: – years

7. Birth date of deceased (mo., day, yr.): December 23 1868

8. AGE: Years	Months	Days	If less than one day
76	9	16	...hrs. ...min.

9. Birthplace: Hagerstown Wash. Co. Md.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own Home

FATHER
12. Name: John Baker
13. Birthplace: Keedysville Md.

MOTHER
14. Maiden name: Jelia McCoy
15. Birthplace: Funkstown Md.

16. Informant: Mr. A. Edmund Baker
Address: Baltimore Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/11/45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown Md.

18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.

19. Oct. 9. 1945 (Date rec'd by registrar) Chas H Boarman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 9 1945 19... at 8:45 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 30, 1936 19... to Oct. 9, 19 45 and that I last saw her alive on October 8, 1945. 19...

Immediate cause of death	DURATION
Pulmonary edema	2 days
Due to: Congestive heart failure	1 week
Due to:	
Other conditions: Diabetes Mellitus	20 yrs
General arteriosclerosis with vascular hypertension.	Indef

(Enter only one cause per line for (a), (b), (c), and (d). Do not enter modes of death)

Major findings of operation: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury: ... Injured at work?

23. SIGNATURE: B B Kneisley M.D. (M. D. or other)
Address: 148 W. Washington St. Date signed: 10/9/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

10386

Reg. Diat. No. 306

1. PLACE OF DEATH:
County Washington
City or town Rural Smithsburg
(If outside city or town limits, write RURAL and give nearest towo)
How long in above place ot death? 12 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give resideoce of mother)
State Md County Washington
City or town Rural Smithsburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. Smithsburg #2
(If rural give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Alfred In Bushman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 13, 1865

8. AGE: Years	Months	Days	If less thao one day
80	0	0	hrs. min.

9. Birthplace Boonsville Md (Town, county, and state)
10. Usual occupation Farm Labor
11. Industry or business
FATHER 12. Name not known
13. Birthplace " "
MOTHER 14. Maiden name not known
15. Birthplace " "
16. Informant Mrs Lloyd B Shawbaugh
Address Smithsburg # 2 Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/16/45 (month) (day) (year)
Cemetery or crematory Boonsboro Lutheran Cemetery
Location Keedysville Rt. Md.
16. Funeral director Walter N Gunn
Address 27 S. Church St. Waynesboro Pa.
19. Oct 15 1945 Geo. W. Ferguson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13 1945, at 10 P. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 16 1945 to Oct 13 1945
and that I last saw him alive on Oct 13 1945

	DURATION
Immediate cause of death Acute cerebral hemorrhage	4 hrs.
Due to Generalized arteriosclerosis	Yrs. ?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Walter H Eichelberger M.D.
M. D. or other
Address Waynesboro Pa Date signed 10/15/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-a)

10387

CERTIFICATE OF DEATH

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Apply every item of information carefully. The MARGIN is especially important. Physicians: please write the causes of death clearly and legibly. FOR BINDING

(I)

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs.
Hospital, institution, or street address where death occurred: Washington County Hosp.
How long in hospital or institution? one day.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 438½ N. Jonathan St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Robert Burns

3.(b) Social Security Number: 214-09-0032

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Widower

6.(b) Name of husband or wife: Mrs. Rose Burns
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 22 1890

8. AGE: Years	Months	Days	If less than one day
55	7	16	..... hrs. ..... min.

9. Birthplace: Lee Town W. Va.
(Town, county, and state)
10. Usual occupation: Bellhop - Daymar Hotel
11. Industry or business

FATHER
12. Name:
13. Birthplace: Not Known

MOTHER
14. Maiden name:
15. Birthplace: Not Known

16. Informant: Marjorie Hill
Address: 440 N. Jonathan St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10-10-45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown, Md.

18. Funeral director: Wm. H. Downey
Address: 291 Frederick St.

19. Oct 10. 1945 (Date rec'd by registrar) Geo. H. Bovard, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 7 1945 at 3:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 18 1945 to Oct 7 1945 and that I last saw h... alive on Oct 7 1945

Immediate cause of death	Coronary occlusion	10/6/45
Due to	Arteriosclerosis	3 / 1
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: H L Porterfield M.D.
M. D. or other
Address: 13 W Washington Date signed: 10/8/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

Dr. Prather

10388

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 Years

Hospital, institution, or street address where death occurred:

II05 Potomac Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: II05 Potomac Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: World War # I

3.(a) FULL NAME: John C Butler

3.(b) Social Security Number: 2I2 0I 3647

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Ela L. Butler

6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): March 29, I887

8. AGE: Years	Months	Days	If less than one day
58	7	25	..... hrs. ..... min.

9. Birthplace: Pittsburgh Allegheny, Co. Pa.
(Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business: American Oil Co.

FATHER
12. Name: No Record
13. Birthplace: No Record

MOTHER
14. Maiden name: No Record
15. Birthplace: No Record

16. Informant: Mrs Ela L. Butler

Address: Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: I0/27 45 (month) (day) (year)

Cemetery or crematory: Antietiam National Cemetery

Location: Sharpsburg, Maryland

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md.

19. Oct. 26 1945 (Date rec'd by registrar) Robert H. Beard Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 25 I945 at 9:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1 1945 to Oct. 25 1945 and that I last saw him alive on Oct. 21 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	2 hrs.
Due to: Hypertension	8 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: (Injured at work?)

23. SIGNATURE: B. Prather M. D. or other

Address: Hagerstown, Md. Date signed: Oct. 26 1945

18

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

10389

Reg. Dist. No. 302

1. PLACE OF DEATH: Washington

County ..... (IF OUTSIDE CORPORATE LIMITS)

City or town Hagerstown (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs

Hospital, Institution, or street address where death occurred: 909 St. Clair

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown (If outside city or town limits, write RURAL and give nearest town)

Street No. 909 St. Clair (If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Jay L. Clark

3. (b) Social Security Number 214- 09-1174

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife Grace E. Clark 6.(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) October 15 1888

8. AGE: Years	Months	Days	If less than one day
56	11	25	..... hrs. ..... min.

9. Birthplace Smithsburg, Washington Co. Md (Town, county, and state)

10. Usual occupation Bookkeeper

11. Industry or business Victor M. Cushwa & Sons

FATHER 12. Name Walter A. Clark

13. Birthplace Smithsburg, Md

MOTHER 14. Maiden name Minnie M. Lyday

15. Birthplace Smithsburg, Md

16. Informant Mrs Jay L Clark

Address Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 12 1945 (month) (day) (year)

Cemetery or crematory Rest Haven

Location Hagerstown Md.

18. Funeral director C. M. Suter & Sons

Address Hagerstown, Md.

19. Oct. 11, 1945 (Date rec'd by registrar) Chas. F. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 10 1945, at 9.09 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death ..... DURATION

chr. myocarditis — 1 yr

Due to acute coronary occlusion

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. .....

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. Robert Wells DEPUTY MEDICAL EXAM. WASH. CO., MD. M. D.

Address Hagerstown, Md. Date signed 10/10/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (53)

CERTIFICATE OF DEATH

10390

Reg. Dist. No. 302

19

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred: 316 Summit Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 316 Summit Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Maria Anna Dillon

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): January 5 1893

8. AGE:

Years	Months	Days	If less than one day
52	9	5	...hrs. ...min.

9. Birthplace: Hagerstown, Washington Co. Md
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER
12. Name: John Dillon
13. Birthplace: Gettysburg Pa

MOTHER
14. Maiden name: Mary Happel
15. Birthplace: Germany

18. Informant: Miss Louise Dillon
Address: Hagerstown, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 12 1945 (month) (day) (year)

Cemetery or crematory: Rose Hill
Location: Hagerstown Md

18. Funeral director: C. m. Suter & Sons
Address: Hagerstown, Md.

19. Oct. 11, 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 10 1945, at 4 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 10 1945, to Oct. 10 1945 and that I last saw h... alive on Oct. 9 1945

	DURATION
Immediate cause of death: Carcenoma: Ear	1 Yr.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. B. Campbell M. D. or other

Address: Hagerstown Md Date signed: Oct. 11/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

10391

CERTIFICATE OF DEATH

★ Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years.
Hospital, institution, or street address where death occurred:
2008 Virginia Ave.
How long in hospital or institution? 30 years.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2008 Virginia ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: Lena Mae Eakle

3. (b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Howard C. Eakle.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July - 26 - 1878

8. AGE: Years	Months	Days	If less than one day
67	3	22	..... hrs. ..... min.

9. Birthplace: near Bakersville Wash. Co. Md.
(Town, county, and state)
10. Usual occupation: Housekeeper
11. Industry or business: Own Home.
FATHER 12. Name: Cornelius Snavely
13. Birthplace: Wash. Co. Md.
MOTHER 14. Maiden name: Catherine Hetzell
15. Birthplace: near Boonsboro Wash. Co. Md.
16. Informant: Mrs. George A. Eakle
Address: 2008 Virginia Ave. Hagerstown Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 21. 1945. (month) (day) (year)
Cemetery or crematory: Bakersville Cemetary
Location: Bakersville Md.
18. Funeral director: Wm J. Bast & Sons
Address: Boonsboro Md.
19. Oct. 20, 1945 (Date rec'd by registrar) Chas H Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 18 1945, at 5:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 19 1945 to Oct. 18 1945
and that I last saw ~~her~~ alive on dead Oct. 18 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	Instant
Due to	
Due to Arteriosclerosis.	2 Years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: Williamsport Md. Date signed 10/19/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (51-E)

CERTIFICATE OF DEATH

14392

Reg. Dist. No. 30d

1. PLACE OF DEATH:

County: Washington

City or town: Antietam--Rural Sharpsburg, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Antietam--rural Sharpsburg, MD
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Charles William Ebersole

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): July 5, 1901

8. AGE: Years	Months	Days	If less than one day
44	3	2	... hrs. ... min.

9. Birthplace: Antietam--Wash.--Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Charles Ebersole
13. Birthplace: Winchester, Va.

MOTHER
14. Maiden name: Mary Holmes
15. Birthplace: Sharpsburg, Md.

16. Informant: Mrs. Mary Mashall
Address: Antietam, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 10. 1945 (month) (day) (year)

Cemetery or crematory: RXXXXXXXXXXXX Mt. View

Location: Sharpsburg, Maryland

18. Funeral director: R. I. Earnshaw

Address: Keedysville, Maryland

19. 10/8/45 (Date rec'd by registrar) E C Boyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 7 1945 at 6:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1. 1945 to Oct 7 1945 and that I last saw him alive on Oct 7 1945

Immediate cause of death	DURATION
Carcinoma of Prostate	
Due to with Metastasis	
to the Spine causing	
Due to Ca of Sigmoid & other	9
internal organs	1
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: No Operation Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Walter H. Shealy M.D.
M. D. or other

Address: Sharpsburg, Md. Date signed: 10/8/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

10393

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlen St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 59 years

Hospital, institution, or street address where death occurred:
Washington County Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give neerest town)

Street No. 850 Summit Avenue
(If rurnl, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Hugh N. Garver

3.(b) Social Security Number 214-09-3858

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

B.(b) Name of husband or wife Clara Fiery Garver

6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) May 2, 1879

8. AGE: Years	Months	Days	If less than one day
66	5	24	..... hrs. ..... min.

9. Birthplace Cavetown, Wash. Co. Md.
(Town, county, and state)

10. Usual occupation Insurance Salesman

11. Industry or business Clarence Keedy & Co.

FATHER
12. Name Daniel H. Garver
13. Birthplace Leitersburg, Maryland

MOTHER
14. Maiden name Jenny Beard
15. Birthplace Chewsville, Maryland

16. Informant Mrs. Hugh N. Garver
Address Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-29-45 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons

Address Hagerstown, Maryland

19. Oct 29 1945 (Date rec'd by registrar) Chas. H. Bowers Registrnr

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 1945, at 11:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15 1930 to Oct 26 1945 and that I last saw h... alive on Oct 26 1945

Immediate cause of death	DURATION
Apoplexy	10 hrs
Due to	
Due to	
Other conditions	

(Include pregnnncy within 3 months of death)

Major findiogs of operations

Date of op.

Aotopsy resnlts

PHYSICIAN: Please underline the canse to which death shoofd be charged statistically.

22. VIOLENCE: If death was due to exfernal causes, fill in the following:

Accident, suicide, or homicide Date of

Where did fnjury occur? (City or town) (County) (State)

fnjured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert P. Conrad, M.D.
M. D. or other

Address Hagerstown, Md Date signed 10-29-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

CERTIFICATE OF DEATH

10394 C.

Reg. Dist. No. 307

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Washington

City or town: Rural Knoxville, Md. R.R. # 1
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 65yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Rural Knoxville Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: R.R. # 1
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Helen Louise Grim

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: Frank W. Grim

6(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): June 26 1862

8. AGE: Years	Months	Days	If less than one day
83	4	1	____ hrs. ____ min.

9. Birthplace: Texas
(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business: Own home

FATHER
12. Name: Thomas Fitzpatric
13. Birthplace: Texas

MOTHER
14. Maiden name: Helen Holden
15. Birthplace: Texas

16. Informant: Frank W. Grim

Address: Knoxville, Md. R.R. # 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 30 1945 (month) (day) (year)

Cemetery or crematory: Cemetery

Location: Brownsville, Md.

18. Funeral director: J.H. Eackles.

Address: Bolivar, W.Va.

19. Oct. 29 1945 (Date rec'd by registrar) Cornelius V. Castle Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 27 1945 4:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 20 1945 to Oct 26 1945

and that I last saw h alive on Oct 26 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	7 days
Due to Cerebral Arteriosclerosis	
Moderate hypertension	
Due to	
Other conditions Chronic Bronchial Asthma	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: —

Of autopsy: —

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury — Injured at work?

23. SIGNATURE: G. L. Grim M. D. or other

Address: Jefferson Md. Date signed 10/29/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45)

CERTIFICATE OF DEATH

10395 Dr. Ditto 21

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 Mons
Hospital, Institution, or street address where death occurred: Broadfording Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: R.F.D. #2
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Daniel Snivley Grove

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Mary
6.(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): Feb. IO I874

8. AGE: Years	Months	Days	If less than one day
71	8	1	____ hrs. ____ min.

9. Birthplace: Bakersville Wash. Co. Md. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Retired

FATHER
12. Name: Daniel Grove
13. Birthplace: Bakersville Md.

MOTHER
14. Maiden name: Mary snivley
15. Birthplace: Bakersville Md.

16. Informant: Mrs. Lester Grove
Address: Hagerstown, Md. R.F.D # 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof IO/I3/45 (month) (day) (year)
Cemetery or crematory: Fairview Cemetery
Location: Keedysville Md.

18. Funeral director: Andrew K Coffman
Address: Hagerstown Md.

19. Oct. 11, 1945 (Date rec'd by registrar) Chas. A. Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: IO/II/45 19 45 at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-1-45 19__ to 10-11-45 19__
and that I last saw ~~deceased~~ alive on 10-10-45 19__

Immediate cause of death	DURATION
Due to Carcinoma Lip	2 yrs.
Due to with metas & lung	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Hagerstown Md. Date signed: 10/11/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr. Porterfield 136 W. Wash. St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (53)

CERTIFICATE OF DEATH

10396

30

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months

Hospital, Institution, or street address where death occurred:

Wash. Co. Hospital

How long in hospital or institution? 6 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pennsylvania County Franklin

City or town Chambersburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 71 North Franklin St.

(If rural, give LOCATION)

2.(a) If veteran, name war None.

3.(a) FULL NAME Florence Harmony

3.(b) Social Security Number None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

B.(b) Name of husband or wife Harry W. Harmony

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May. 2 - 1884

8. AGE:

Years	Months	Days	If less than one day
61	5	16	..... hrs. ..... min.

9. Birthplace Benevola Wash. Co. Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home.

FATHER 12. Name Hilliary Lynch

13. Birthplace near Boonsboro Wash. Co. Md.

MOTHER 14. Maiden name Mary O'Neal

15. Birthplace near Myersville Fred. Co. Md.

16. Informant Harry W. Harmony

Address 71 N. Franklin St. Chambersburg Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 22 1945 (month) (day) (year)

Cemetery or crematory Boonsboro Cemetary

Location Boonsboro Md.

18. Funeral director W.H.S. Bast & Sons

Address Boonsboro Md.

19. Oct. 20, 45 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 19 45 at 9 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 24 19 45 to Oct 18 19 45

and that I last saw h.. alive on Oct 18 19 45

Immediate cause of death	DURATION
Carcinoma of Breast	5
metastasis to Peritoneum	1
Due to Syncope	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H S Porterfield M D. M. D. or other

Address 136 W Wash. St Date signed 10/20/45

38

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1945)

CERTIFICATE OF DEATH

10397 Reg. Dist. No. 302

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Washington
City or town Hagerstown, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution Washington County Hospital
Stay in hospital or inst. (yrs., or mos., or days) 9 days
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Penna. County Franklin
City or town (Upton) Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Greencastle R.D. #2
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Rev. Amos Hawbaker

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of ~~husband~~ or wife Elizabeth Hawbaker
6(c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) April 25, 1872

8. AGE:

Years	Months	Days	If less than one day
73	6	5	hrs. min.

9. Birthplace Welsh Run, Franklin Co., Pa.
(Town, county, and state)
10. Usual occupation Farming
11. Industry or business
FATHER 12. Name David D. Hawbaker
13. Birthplace Welsh Run, Pa.
MOTHER 14. Maiden name Mary Meyers
15. Birthplace Mercersburg, Pa. R.D.
16. Informant Dora Hawbaker
Address Mercersburg Pa.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 2, 1945 (month) (day) (year)
Cemetery or ~~crematory~~ Meyers
Location Mercersburg, Pa. R.D. #2
18. Funeral director D. J. Grininger & Son
Address Mercersburg, Pa.
19. Nov-1 1945 Chas. H. Boward, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 / 30 1945, at 1:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/1 1939, to 10/30 1945, and that I last saw him alive on 10/30 1945

Immediate cause of death	DURATION
Respiratory depression following Sodium pentothal Anesthesia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations None
Of autopsy None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. C. Bruce M. D. ~~or other~~
Address Greencastle, Pa. Date signed 10/31/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10398 No 7

Reg. Diat. No. 305

1. PLACE OF DEATH:
County: Washington
City or town: Breathedsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? from 7/13/45
Hospital, Institution, or street address where death occurred:
Md. State Reformatory for Males
How long in hospital or institution? from 7/13/45

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 912 N. Calhoun St., Baltimore
(If rural, give LOCATION)
2.(a) If veteran, name war: unknown

3.(a) FULL NAME: CHARLES H HILL

3.(b) Social Security Number: 213 12 2592

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	negro	married

6.(b) Name of husband or wife: Evelyn Blaney Hill
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 12/3/11

8. AGE: Years	Months	Days	If less than one day
33	10	23	..... hrs. ..... min.

9. Birthplace: Baltimore Md.
(Town, county, and state)
10. Usual occupation: laborer
11. Industry or business

FATHER
12. Name: Charles Hill (deceased)
13. Birthplace: Baltimore

MOTHER
14. Maiden name: Mary Hill
15. Birthplace: Baltimore

16. Informant: Md. State Reformatory for Males
Address: Breathedsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 28, 1945 (month) (day) (year)
Cemetery or crematory: U.S. National Cemetery
Location: Baltimore, Md.

18. Funeral director: Adolpheous Halstead
Address: Baltimore, Md.

19. Oct 26 19 45 (Date rec'd by registrar) John L. Bart Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 26 19 45, at 12:42 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 23 19 43 to Oct 26 19 45
and that I last saw h.im alive on Oct 26 19 45

Immediate cause of death	DURATION
Pulm. Tuberculosis	Nov. 1942
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Robert P. Conrad, M. D. M. D. or other
Address: Hagerstown, Md. Date signed 10-26-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47-2

10399

CERTIFICATE OF DEATH

Reg. Diat. No. 303

1. PLACE OF DEATH:

County: Washington

City or town: Big Spring, Md. Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 years

Hospital, institution, or street address where death occurred:
Near McCoys Ferry

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Big Spring, Md. Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. McCoys Ferry Dist.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Seibert I. Hoffman

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anna Pauline

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Mar. 14, 1884

8. AGE: Years	Months	Days	If less than one day
61	7	13	..... hrs. ..... min.

9. Birthplace: Woodsville Wash. Md.
(Town, county, and state)

10. Usual occupation: Farming

11. Industry or business

FATHER
12. Name: Jacob Hoffman
13. Birthplace: Wash. Co., Md.

MOTHER
14. Maiden name: Georgiana Eakle
15. Birthplace: Wash. Co., Md.

16. Informant: Mrs. Anna P. Hoffman
Address: Big Spring, Md. R F D

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 31, 1945 (month) (day) (year)

Cemetery or crematory: St. Paul's Cemetery

Location: Near Clear Spring, Md. Route 40

18. Funeral director: Snyder-Rowland Funeral Home

Address: Clear Spring, Md.

19. Oct 28 1945 (Date rec'd by registrar) Joseph W. Murray Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 27, 1945 11.55 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 1945, to Oct. 27. 1945 and that I last saw him alive on Oct 27. 1945

Immediate cause of death	DURATION
Carcinoma of Rt. Lung	7 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: David P. Brewer M.D. M. D. or other

Address: Clear Spring Md. Date signed: Oct 28, 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21-20)

CERTIFICATE OF DEATH

10460

Reg. Dist. No. 20 3

1. PLACE OF DEATH:

County Washington

City or town Clearspring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? 25 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Clearspring

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George Washington Hose

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Mary Hose

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 5 1864

8. AGE: Years	Months	Days	If less than one day
80	6	26	..... hrs. ..... min.

9. Birthplace Washington Co. (Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business

FATHER 12. Name Jerry Hose

13. Birthplace Washington Co.

MOTHER 14. Maiden name Not Known

15. Birthplace ... ..

16. Informant Miss. Annie Hose

Address Clearspring Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 2 1945 (month) (day) (year)

Cemetery or crematory Mt. Tabler Cemetery

Location Fairview Md.

18. Funeral director Snyder-Rowland

Address Clearspring, Md.

19. Nov 2 1945 (Date rec'd by registrar) Joseph W. Murray Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31 1945, at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1945, to Oct 31 1945

and that I last saw h... alive on ..... 19...

	DURATION
Immediate cause of death Myocarditis	6 mo.
Due to Chr. Prostatitis	Hyp.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE David P. Brewer M.D. M. D. or other

Address Clear Spring Md. Date signed 11/2/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

10401 7

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 43 Years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Clearspring

(If outside city or town limits, write RURAL end give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Francis Peter Hull

3.(b) Social Security Number: 214-09-6353

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Olive Hull

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 23 1901

8. AGE: Years	Months	Days	If less than one day
43	11	12	..... hrs. ..... min.

9. Birthplace: Washington Co.
(Town, county, and state)

10. Usual occupation: Helper On Ice Truck

11. Industry or business: Hagerstown Ice Co.

FATHER
12. Name: Francis P. Hull
13. Birthplace: Washington Co.

MOTHER
14. Maiden name: Elizabeth Hull
15. Birthplace: Washington Co.

16. Informant: Mrs. Olive Hull

Address: Clearspring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 8 1945 (month) (day) (year)

Cemetery or crematory: Rose Hill

Location: Clearspring, Md.

18. Funeral director: Snyder-Rowland Funeral Home

Address: Clearspring, Md.

19. Nov. 7. 1945 (Date rec'd by registrar) Clark H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 5 1945 at 7.30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Epileptic	5 yrs
Cerebral clot	
Due to: Hemorrhage & shock	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Accident Date of 10/5/45

Where did injury occur? Hagerstown (City or town) Washington (County) Md. (State)

Injured at home, farm, industry, public place (where?) 20 E. Baltimore St.

Means of injury: Run over by truck Injured at work? Yes

23. SIGNATURE: J. Robert Wells DEPUTY MEDICAL EXAM. WASH. CO., MD.

M. D. or other

Address: Hagerstown, Md. Date signed 10/6/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

10402

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (53)

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County Washington
City or town Snnarpsburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Sharpsburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Miss Laura Louisa Keplinger

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife No
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 1842

8. AGE: Years	Months	Days	If less than one day
(92) 93	10		..... hrs. ..... min.

9. Birthplace Sharpsburg (Town, county, and state)
10. Usual occupation Housework
11. Industry or business Home
FATHER 12. Name Jonathan Keplinger
13. Birthplace Beaver Creek Md
MOTHER 14. Maiden name Marie Ann Kenny
15. Birthplace Beaver Creek Md
16. Informant Mrs. Edgar Beachley
Address Sharpsburg Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 28 1945 (month) (day) (year)
Cemetery or crematory Mt. View Cem
Location Sharpsburg Md
19. Funeral director Edith V. Leaf
Address Williamsport Md.
19. ..... 19..... (Date rec'd by registrar) E. G. Boyer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25 1945, at 4:50 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from about march 1 1945 to Oct 25 1945
and that I last saw h.... alive on Oct 25 1945

Immediate cause of death	DURATION
Epithelioma of the face	2 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Walter H. Shealy M.D. M. D. or other
Address Sharpsburg, Md. Date signed 10/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

32

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 57-2

Dr. Layman 14403

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 Yrs.
Hospital, institution, or street address where death occurred:
59 East Antietam St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 59 E. Antietam St.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME Mrs Catherine Bell Lenharr

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife William Newton
6.(c) If alive, give age 75 years
7. Birth date of deceased (mo., day, yr.) Nov. 26 1868

8. AGE: Years	Months	Days	If less than one day
76	10	26	....hrs. ....min.

9. Birthplace Ringgold Wash. Co. Md. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own Home

FATHER
12. Name Daniel Bell
13. Birthplace Bowmans Mill Md.

MOTHER
14. Maiden name Susan Stull
15. Birthplace Bowmans Mill Md.

16. Informant W. Newton Lenharr
Address Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/24/45 (month) (day) (year)
Cemetery or crematory Mausolem Rose Hill Cemetery
Location Hagerstown, Md.
18. Funeral director Andrew K. Coffman
Address Hagerstown, Md.

19. Oct. 22 1945 (Date rec'd by registrar) Ghast Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22 1945 at 6:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 14 1945 to Oct. 21 1945 and that I last saw her alive on Oct. 21 1945

	DURATION
Immediate cause of death Myocarditis, Chronic	
Due to	
Due to	
Other conditions Clinical diagnosis was: Tuberculosis of the Hypopharynx (?) Unqualified. (Include pregnancy within 3 months of death) CWBR	

Major findings of operation No exploratory operation was done. Date of op.
Autopsy results No autopsy was done.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Milton Layman M.D. M. D. or other
Address Hagerstown Md. Date signed 10/22/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 1

27

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12)

CERTIFICATE OF DEATH

10404

★ Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Days

Hospital, Institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State West Virginia County Berkely

City or town Falling Waters

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D.

(If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME Margaret Helen Magruder

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife None

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) September 4 1940

8. AGE: Years	Months	Days	If less than one day
5	1	12	....hrs. ....min.

9. Birthplace Martinsburg Berkely Co. W.Va.

(Town, county, and state)

10. Usual occupation None

11. Industry or business —

FATHER

12. Name Harry Files Magruder

13. Birthplace Jefferson Co. W.Va.

MOTHER

14. Maiden name Selia Chaney

15. Birthplace Downsville Md.

16. Informant Harry F. Magruder

Address Fallung Waters W.Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/19/45 (month) (day) (year)

Cemetery or crematory Elmwood Cemetery

Location Sheperdstown W.Va.

18. Funeral director Coffman & Kogleschatz

Address Martinsburg W.Va.

19. Oct 18 1945 Elsie H. Bowers, Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

P

20. DATE OF DEATH October 16 1945 19.... at 3.50 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/14/45 19.... to 10/16/45 19....

and that I last saw h... alive on 10/6/45 19....

Immediate cause of death	Tetanus	DURATION
Due to		
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... injured at work?

23. SIGNATURE G. F. Grove M. D. or other

Address Sheperdstown, W.Va. Date signed 10/18/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

9

10405

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 303

1. PLACE OF DEATH:

County: Washington

City or town: Clear Spring, Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred:
Route 40 near Clear Spring

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Clear Spring, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route 40 West
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: James David Mann

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary E. Mann

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 12, 1868

8. AGE: Years	Months	Days	If less than one day
77	5	17	..... hrs. ..... min.

9. Birthplace: Allegheny Co., Md.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: David Mann
13. Birthplace: Allegheny Co., Md.

MOTHER
14. Maiden name: Lucy Bishop
15. Birthplace: Allegheny Co., Md.

16. Informant: Benjamin Mann
Address: Martinsburg, W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 1, 1945 (month) (day) (year)

Cemetery or crematory: St. Paul's Cemetery

Location: Route 40 Near Clear Spring, Md.

18. Funeral director: Snyder-Rowland Funeral Home

Address: Clear Spring, Md.

19. Nov 1 19 45 (Date rec'd by registrar) Joseph W. Murray Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 29th 1945 19 ..... at 4. 7A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 ..... to ..... 19 .....

and that I last saw h..... alive on ..... 19 .....

Immediate cause of death ..... DURATION

Coronary arteriosclerosis ..... 1 yr.

Due to: Acute coronary occlusion

Due to:

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: S. Robert Weedon DEPUTY MEDICAL EXAM. WASH. CO., MD.
M. D. or other

Address: Hagerstown, Md. Date signed 10/31/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

10406

Reg. Dist. No. 301

1. PLACE OF DEATH:
County: Washington County
City or town: Williamsport, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
106 Conococheague St. Williamsport
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Williamsport, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 106 Conococheague St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Issiah Mason

3.(b) Social Security Number: 215-05-9865

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Nina Mentzer Mason
6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): May 8 1902

8. AGE: Years	Months	Days	If less than one day
43	4	10	hrs. min.

9. Birthplace: Janes Springs Md. (Town, county, and state)
10. Usual occupation: Leasther Grainer
11. Industry or business: Tannery

FATHER
12. Name: Bayne Mason
13. Birthplace: Gano W. Va.

MOTHER
14. Maiden name: Fannie Kees
15. Birthplace: Ohio

16. Informant: Nina Mentzer Mason
Address: 106 Conococheague St Williamsport

17. (Burial, cremation, or removal. Which?) Burial
Date thereof: Oct 22 1945 (month) (day) (year)
Cemetery or crematory: Greenlawn Cemetery
Location: Williamspport, Maryland

18. Funeral director: Edith V Leaf
Address: #7 Church St. Williamsport, Md.

19. (Date rec'd by registrar) Oct. 22 1945 Mrs E Lee McElroy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 17, 1945, at 10:10 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct. 15 1945 to Oct 17 1945
and that I last saw h.... alive on Oct. 17 1945

Immediate cause of death	DURATION
Coronary Occlusion	2 days
Due to	
Due to Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: Williamsport Md. Date signed: 10/19/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10407

CERTIFICATE OF DEATH

Reg. Dist. No. 304

1. PLACE OF DEATH:
County: Washington
City or town: Rural - Hancock
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
~~Hospital, Institution, or~~ street address where death occurred:
Hancock, Route 2
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Washington
City or town: Rural - Hancock
(If outside city or town limits, write RURAL and give nearest town)
Street No. Orchard Ridge
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME
Lucille Seburn McCarty

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Warren McCarty
6.(c) If alive, give age: 20 years

7. Birth date of deceased (mo., day, yr.): Aug. 6, 1916

8. AGE:

Years	Months	Days	If less than one day
29	2	18	... hrs. ... min.

9. Birthplace: Sylvan, Fulton, Penna.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: —

FATHER
12. Name: Albert Seburn
13. Birthplace: Penna.

MOTHER
14. Maiden name: Viola Kiefer
15. Birthplace: Penna.

16. Informant: Husband
Address: Hancock, Route 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 28, 1945 (month) (day) (year)
Cemetery or ~~crematory~~: Orchard Ridge Church
Location: Orchard Ridge
18. Funeral director: Charles R. Bast
Address: Hancock Md

19. Oct 27 1945 (Date rec'd by registrar) John T. Keller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 24 1945, at 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 24 1945 to Oct 24 1945
and that I last saw her alive on Oct 24 1945

Immediate cause of death	DURATION
Heart failure	
Due to: Uremia	
Due to: Flu	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: R. M. Kapper M.D. M. D. or other
Address: Hancock Md Date signed: 10/28/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

10408 28

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, Institution, or street address where death occurred:
1017 Oak Hill Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1017 Oak Hill Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Alvaretta F. McClave

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: William H. McClave

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 14, 1860

8. AGE: Years	Months	Days	If less than one day
85	10	3	..... hrs. ..... min.

9. Birthplace: Hackettstown, N.J.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER
12. Name: Charles F.R. Moore
13. Birthplace: Dover, N.J.

MOTHER
14. Maiden name: Elizabeth Malloy
15. Birthplace: Waverly, N.Y.

16. Informant: Mrs. Henry Holzapel

Address: Hagerstown, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof 10-20-45 (month) (day) (year)

Cemetery or crematory: Greenwood Cemetery

Location: Brooklyn, N.Y.

18. Funeral director: C. M. Suter & Sons

Address: Hagerstown, Maryland

19. Oct. 19 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 17 1945 at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 17 1945 to Oct 17 1945 and that I last saw h. alive on Oct 17 1945

Immediate cause of death	DURATION
Arteriosclerosis	
Due to: Coronary Thrombus	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: A. D. Landes M. D. or other

Address: Hagerstown Md Date signed Oct 18 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Ba)

10409

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 48 years

Hospital, institution, or street address where death occurred:

29 Armstrong Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 822 Wash. Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Lillian McClelland

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Claude H. McClelland

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 27, 1897

8. AGE:

Years	Months	Days	If less than one day
48	4	10	hrs. min.

9. Birthplace: Hagerstown, Wash. Co., Md.
(Town, county, and state)

10. Usual occupation: Home Duties

11. Industry or business

FATHER

12. Name: Andrew Morgan

13. Birthplace: Wash. Co., Md.

MOTHER

14. Maiden name: Martha Rohrer

15. Birthplace: Wash. Co., Md.

16. Informant: Claude H. McClelland

Address: 822 Wash. Ave. Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 10, 1945 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Md.

18. Funeral director: Fred W. Kraiss

Address: Hagerstown, Md.

19. October 9 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 6, 1945 at 11:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 25 1943, to Oct 6 1945

and that I last saw her alive on Oct. 6 1945

Immediate cause of death	DURATION
Pulmonary edema	
Uremia	
Due to: Cerebral hemorrhage	
Due to: Hypertension Disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. Allen Simpson M.D. M. D. or other

Address: Hagerstown, Md. Date signed: 10-8-45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10410

Reg. Dist. No. 304

1. PLACE OF DEATH:

County: Washington

City or town: Hancock, Rural 2
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hancock, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Henry McCormick

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Leslie McCormick

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): July 12 1878

8. AGE: Years	Months	Days	If less than one day
67	3	4	...hrs. ...min.

9. Birthplace: Washington County
(Town, county, and state)

10. Usual occupation: Farming

11. Industry or business

FATHER
12. Name: John McCormick
13. Birthplace: Washington County

MOTHER
14. Maiden name: Annie Long
15. Birthplace: Washington County

16. Informant: Mrs. Leslia McCormick

Address: Hancock, Rural 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Octob. 20 1945 (month) (day) (year)

Cemetery or crematory: St. Peters Catholic

Location: Hancock, Md.

18. Funeral director: Snyder-Rowland

Address: Hancock, Md.

19. ...19... (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 16 19 45, at 3:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...

and that I last saw h... alive on ...19...

Immediate cause of death: Chronic myocarditis

	DURATION
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: E M Shafer M. D. or other

Address: Hancock, Md Date signed: 10/17/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

10411

40

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 years

Hospital, institution, or street address where death occurred:
39 West Side Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 39 West Side Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: James H. McFarland

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Amanda McFarland 6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): February 14, 1860

8. AGE: Years	Months	Days	If less than one day
85	8	17	____ hrs. ____ min.

9. Birthplace: Bentonville, Va. (Town, county, and state)

10. Usual occupation: Retired Laborer

11. Industry or business

FATHER — 12. Name: Robert McFarland

FATHER — 13. Birthplace: Bentonville, Va.

MOTHER — 14. Maiden name: Not Known

MOTHER — 15. Birthplace: Bentonville, Va.

16. Informant: Peter S. McFarland

Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-2-45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Maryland

18. Funeral director: C. M. Suter & Sons

Address: Hagerstown, Maryland

19. Nov 2 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 31 1945, at 9.50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 5, 1945, to October 31 1945 and that I last saw h. alive on October 30, 1945

Immediate cause of death	DURATION
Coronary occlusion	1 hr.
Due to: Coronary arteriosclerosis	
Due to:	
Other conditions: Severe hypertension	about 4 years

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: P B Yarnell MD M. D., or other

Address: Hagerstown Md Date signed Nov. 1 1945

12

10412

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (52-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr.
Hospital, institution, or street address where death occurred:
216 South Prospect Street
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 216 South Prospect Street
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Florence Dock McGowan

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Edward C. McGowan
6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): June 26, 1892

8. AGE: Years	Months	Days	If less than one day
53	3	12	...hrs. ...min.

9. Birthplace: Waynesboro, Franklin Co., Pa.
(Town, county, and state)
10. Usual occupation: House wife
11. Industry or business: —

FATHER
12. Name: William B. Dock
13. Birthplace: Waynesboro, Pa.

MOTHER
14. Maiden name: Nellie F. Balsley
15. Birthplace: Chambersburg, Pa.

16. Informant: Edward C. McGowan
Address: 216 South Prospect St., Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 11, 1945 (month) (day) (year)
Cemetery or crematory: Green Hill Cemetery
Location: Waynesboro, Pa.
18. Funeral director: Charles R. Bast
Address: Hancock, Md.

19. October 9 1945 (Date rec'd by registrar) Elast H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 8 1945 at 8:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from: Mar 16 1945 to Oct 8 1945
and that I last saw her alive on Oct 8 1945

Immediate cause of death	DURATION
Carcinoma Bladder	1 Yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: H H Porterfield M.D.
M. D. or other
Address: 136 W Washington Date signed: 10/9/45

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1

20

10413

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
1912 Lexington Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1912 Lexington Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William L. Middlekauff

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Emma Middlekauff
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 2 1858

8. AGE: Years	Months	Days	If less than one day
87	0	8	..... hrs. ..... min.

9. Birthplace: Hagerstown Washington Co. Md
(Town, county, and state)
10. Usual occupation: Retired Contracter
11. Industry or business

FATHER
12. Name: Joseph Middlekauff
13. Birthplace: Hagerstown, Md.

MOTHER
14. Maiden name: Mary Eliza Fiery
15. Birthplace: Hagerstown Md

16. Informant: Mrs. John Howard
Address: Hagerstown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 12 1945 (month) (day) (year)
Cemetery or crematory: Rose Hill
Location: Hagerstown, Md
18. Funeral director: C. M. Suter & Sons
Address: Hagerstown, Md.

19. Oct. 11. 1945 (Date rec'd by registrar) Chas. H. Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 10 1945, at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 10 1943 to Oct. 10 1945 and that I last saw him alive on Oct. 10 1945

	DURATION
Immediate cause of death: Carcinoma of Lung	3 yrs
Due to: Carcinoma of Lip	5 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. Luther Hagerstown, Md. M. D. or other
Address: Date signed 10-11-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH Dr.B.B. Kneisley

2411 N. Charles St., Baltimore (B-D)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 10413 6

1. PLACE OF DEATH:
County Washington
City or town Hagerstown,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 Years
Hospital, institution, or street address where death occurred: Walnut Point Road
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown, R.F.D.2
(If outside city or town limits, write RURAL and give nearest town)
Street No. Walnut Point Road
(If rural, give LOCATION)
2.(a) If veteran, name war No

3. (a) FULL NAME: Charles Lewis Miller

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ella.

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): December 22, 1870

8. AGE: Years	Months	Days	If less than one day
74	10	8	..... hrs. ..... min.

9. Birthplace: Westminster Carroll Co. Md.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Retierd

FATHER
12. Name: John Miller
13. Birthplace: Westminster , Maryland

MOTHER
14. Maiden name: Elizabert Miller
15. Birthplace: Westminster, Maryland

16. Informant: Mrs Charles L. Miller
Address: Hagerstown, Md, R.D.2

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 1, 1945 (month) (day) (year)
Cemetery or crematory: Dunkard Cemetery
Location: Broadfording, Near Cearfoss, Md

18. Funeral director: Andrew K. Coffman
Address: Hagerstown, Md.

19. Oct. 31 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 30, 1945 at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 2, 1940 to Oct. 30, 1945 and that I last saw him alive on Oct. 30, 1945

Immediate cause of death	DURATION
Hypostatic pneumonia	2 days
Due to	
Due to	
Other conditions Cerebral hemorrhage	2 yrs.
Chronic myocarditis	4 yrs.

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: O. B. Kneisley M.D. M. D. or other
Address: 148 W. Washington St. Date signed 10/31/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Kritzer 6

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-C)

CERTIFICATE OF DEATH

10415

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred:
134 Ross St.
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 134 Ross St.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME Mrs. Betty Jane Morrow

3.(b) Social Security Number 212-24-6417

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fenale	White	Married

6.(b) Name of husband or wife Harry C.
6.(c) If alive, give age 51 years
7. Birth date of deceased (mo., day, yr.) June 8 1898

8. AGE: Years	Months	Days	If less than one day
47	3	24	....hrs. ....min.

9. Birthplace Baxter Berkeley Co. W.Va.
(Town, county, and state)
10. Usual occupation Knitter
11. Industry or business Inter Waven Hosiery Co.
FATHER 12. Name Porter Basore
13. Birthplace Hedgesville W.Va.
MOTHER 14. Maiden name Susan Weller
15. Birthplace Hedgesville W.Va.
16. Informant Harry C. Morrow
Address Hagerstwon Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/4/45 (mouth) (day) (year)
Cemetery or crematory Providence U.B. Cemetery
Location near Hedgesville W.Va.
18. Funeral director Andrew K. Coffman
Address Hagerstown Md.
19. Oct 4 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH October 2 1945 at 1 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 2 1945 to Oct 2 1945 and that I last saw her alive on Oct 2 1945

Immediate cause of death	DURATION
Acute Cardiac Dilatation	Instantaneous
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ....Date of op. ....
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide .... Date of ....
Where did injury occur? .... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury Injured at work?

23. SIGNATURE Chas H Bowers M.D. M. D. or other
Address Hagerstown md. Date signed Oct 2-1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

7

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

10416

Reg. Dist. No. 303

1. PLACE OF DEATH:

County: Washington

City or town: Big Pool Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Big Pool Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Nelia Catherin Myers

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Roy P. Myers

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): October 18 1887

8. AGE: Years	Months	Days	If less than one day
58	0	6	hrs. min.

9. Birthplace: Franklin CO. Pa.
(Town, county, and state)

10. Usual occupation: Home Work

11. Industry or business

FATHER

12. Name: Samuel Thomas

13. Birthplace: Franklin Co. Pa.

MOTHER

14. Maiden name: Carolina Brewer

15. Birthplace: Franklin Co. Pa.

16. Informant: Roy P. Myers

Address: Big Pool Md Rural

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 29 1945 (month) (day) (year)

Cemetery or crematory: St. Pauls

Location: Near Clearspring, Md.

18. Funeral director: Snyder-Rowland

Address: Hancock, Md.

19. Oct 28 1945 (Date rec'd by registrar) Joseph W. Murray Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 24 1945, at 10:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 24 1945, to Oct 24 1945

and that I last saw h[illegible] alive on Oct 24 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to: Hypertension.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: E. M. Shaffer M. D. or other

Address: Hancock Md Date signed: 10/27/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

10417

★ Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 71 years

Hospital, institution, or street address where death occurred:

237 Jefferson Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town HAGERSTOWN (WITHIN CORPORATE LIMITS)

(If outside city or town limits, write RURAL and give nearest town)

Street No. 237 Jefferson Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James William Osborne

3.(b) Social Security Number 214-09-8767

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Nellie L. Osborne

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 25, 1873

8. AGE: Years 71 | Months 9 | Days 10 | If less than one day ..... hrs. ..... min.

9. Birthplace Hagerstown, Wash. Co., Md. (Town, county, and state)

10. Usual occupation Saw Filer

11. Industry or business

FATHER

12. Name James P. Osborne

13. Birthplace Wash. Co., Md.

MOTHER

14. Maiden name Eliza Ridenour

15. Birthplace Wash. Co., Md.

16. Informant Mrs. Nellie L. Osborne

Address 237 Jefferson St. Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 7 1945 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Md.

18. Funeral director Fred W. Kraiss

Address Hagerstown, Md.

19. Oct. 7. 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5, 1945 12:45 at A. M. P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15, 1927 to Oct 5, 1945 and that I last saw h[illegible] alive on Oct. 4, 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	4 days.
Hemiplegia - R/H	3 w.
Due to Arteriosclerosis	8 years.
Due to Congestive Heart Failure	July 1945
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations no

Date of op.

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Houdyeger M. D. or other

Address Hagerstown, Md. Date signed Oct. 5, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
OCT 9 1945
BUREAU V. R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

10418

CERTIFICATE OF DEATH

Reg. Diat. No. 300

1. PLACE OF DEATH:

County WASHINGTON

City or town RURAL--ANTIETAM--SHARPSBURG R. F. D.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? LIFE

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County WASHINGTON

City or town ANTIETAM--RURAL SHARPSBURG, MD
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MARY ESTELLA OTZELBERGER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6.(b) Name of husband or wife PETER OTZELBERGER

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 3, 1870

8. AGE: Years	Months	Days	If less than one day
74	10	4	hrs. min.

9. Birthplace ANTIETAM- WASHINGTON CO. MARYLAND
(Town, county, and state)

10. Usual occupation HOME DUTIES

11. Industry or business

FATHER
12. Name JOHN A. GRAY
13. Birthplace SHARPSBURG, MARYLAND

MOTHER
14. Maiden name MARY ANN HOFFMASTER
15. Birthplace SHARPSBURG, MARYLAND

16. Informant MRS. F. A. GRAY
Address SHARPSBURG, MARYLAND R. F. D.

17. BURIAL Date thereof OCT. 10, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory MT. VIEW

Location SHARPSBURG, MARYLAND

18. Funeral director R. I. EARNSHAW

Address KEEDYSVILLE, MARYLAND

OCT 8 1945
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 7 19 45 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 3 19 45 to 19

and that I last saw h alive on Oct 3 19 45

	DURATION
Immediate cause of death Pyonic Myocarditis.	?
Due to	
Due to	
Other conditions Senile Arteriosclerosis Diabetes Mellitus	5 yrs 3 months

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter H. S. Fearhake M.D. M. D. or other

Address Sharpsburg, Md. Date signed 10/8/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS/A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr. Ditto

CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown R # 2
(If outside city or town limits, write RURAL and give nearest town)
How long in abeve place ef death? 10 Years
Hospital, institution, or street address where death eccurred:
Huyetts Cross Roads
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For uewborn infants give residence of mother)
State: Maryland County: Washington
City or town: Huyetts
(If outside city or town limits, write RURAL end give ueareat town)
Street No. Hagerstown, R# 2 Md.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME
Samuel Pfoch

3. (b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband er wife: None
6.(c) If alive, give age: —
7. Birth date of deceased (mo., day, yr.): July 32 1866

8. AGE: Years	Months	Days	If less than one day
79	3	6	...hrs. ...min.

9. Birthplace: Wilsons Wash. Co. Md.
(Town, county, and atate)
10. Usual occupation: Laborer
11. Industry or business: --

FATHER
12. Name: No Record
13. Birthplace: No Record

MOTHER
14. Maiden name: No Record
15. Birthplace: No Record

16. Informant: Roy Sprecher
Address: Hagerstown, R# 2 Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/30/45 (month) (day) (year)
Cemetery or crematory: Luthern Cemetery
Location: Clearspring, Md.

18. Funeral director: Andrew K. Coffman
Address: Hagerstown, Md.

19. 10-30-45 (Date rec'd by registrar) Leroy M. Foltz Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 28 19 45, at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1-45 19... to Oct 28 19 45 and that I last saw ~~him~~ alive on Oct 27-45 19...

Immediate cause of death	DURATION
Cerebral Hemorrhage	48 hrs
Due to	
Due to: Cerebral sclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operatioos: ...Date ef ep. ...
Autopsy results: ...
PHYSICIAN: Please underlioe the cause to which death shoold be charged statisticaBy.

22. VIOLENCE: If death was due te external causes, fill in the following:
Accident, suicide, or hemicide: ... Date ef ...
Where did injury eccur? ... (City or town) (County) (State)
Injured at home, farm, lodustry, public place (where?) ...
Means of injury ... Injured at werk?

23. SIGNATURE: [signature] M. D. or Other
Address: Hagerstown Md. Date signed: 10/30/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

34

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

10420

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 Years
Hospital, institution, or street address where death occurred: 309 Liberty Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 309 Liberty Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Otha J. Poffenberger

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

B.(b) Name of husband or wife: Nellie Poffenberger
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 21, 1875

8. AGE: Years	Months	Days	If less than one day
70	8	6	hrs. min.

9. Birthplace: Williamsport, Washington, Md. (Town, county, and state)
10. Usual occupation: Assistant Market Master
11. Industry or business

FATHER
12. Name: William H. Poffenberger
13. Birthplace: Maryland

MOTHER
14. Maiden name: Eleanor Hoffman
15. Birthplace: Maryland

16. Informant: Mrs. Ralph Funkhouser
Address: Hagerstown Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 29, 1945 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown Maryland.

18. Funeral director: Fred W. Kraiss
Address: Hagerstown Maryland

19. Oct. 28. 1945 (Date rec'd by registrar) Chas. H. Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 29 1945, at 4:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 10 1945, to October 29 1945
and that I last saw h. alive on October 14. 1945

	DURATION
Immediate cause of death: Coronary Occlusion	½ hour
Due to: Coronary arteriosclerosis	5 Years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

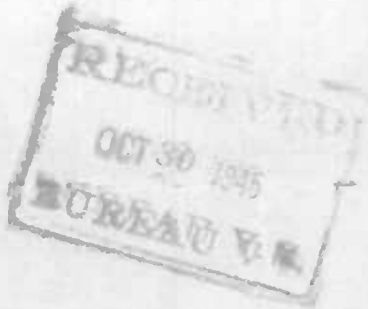
22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) None
Means of injury: Injured at work?

23. SIGNATURE: R B Nowcomer M.D. M. D. or other
Address: Hagerstown, Md. Date signed: Oct 26 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

Dr. Earl Young

★ 10421

Reg. Dist. No. 302

15

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Years

Hospital, institution, or street address where death occurred:

45 Elizabeth St.

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 45 Elizabeth St.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Mrs. Mabel Barber Richardson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife: Albert

6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): July 6 1900

8. AGE: Years	Months	Days	If less than one day
45	3	2	...hrs. ...min.

9. Birthplace: Hagerstown Wash. Co. Md.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own Home

FATHER — 12. Name: John T. Barber

FATHER — 13. Birthplace: Williamsport Md.

MOTHER — 14. Maiden name: Emma C. Knave

MOTHER — 15. Birthplace: Harrisburg Pa.

16. Informant: Mrs. catherine L. Chaney

Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/11/45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown Md.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md.

19. Oct 9, 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH: October 8 1945, 19..., at 7.15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3.28.45, 19..., to 10.8.45, 19...

and that I last saw her alive on 9.28.45, 19...

Immediate cause of death	DURATION
Congested heart failure	
Due to: Hypertensive heart disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: 148 N. Potomac St. Date signed: 10.9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10422

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
327 W. Washington St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 327 W. Washington St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Victor Martin St. Clair

3. (b) Social Security Number: 716-09-8763

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Ella M. St. Clair
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 16, 1875

8. AGE: Years	Months	Days	If less than one day
69	11	9	hrs. min.

9. Birthplace: Mason Dixon, Wash. Co., Md. (Town, county, and state)
10. Usual occupation: Retired Penn. R. R. Employee
11. Industry or business

FATHER
12. Name: Robert St. Clair
13. Birthplace: Washington Co., Md.

MOTHER
14. Maiden name: Catherine Shank
15. Birthplace: Washington Co., Md.

16. Informant: Mrs. Irene Jacobs
Address: 327 W. Washington St. Hagerstown

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 28, 1945 (month) (day) (year)
Cemetery or crematory: Macedonia U. B. Cemetery
Location: Macedonia, Pa.
18. Funeral director: Fred W. Kraiss
Address: Hagerstown, Md.

19. Oct. 28, 1945 (Date rec'd by registrar) Chas. F. Boward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 25, 1945 19 at A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 - 45 to Oct 25 1945
and that I last saw him alive on Oct 22 - 45 19

Immediate cause of death	DURATION
Carcinoma	
Due to: Stomach	1 year
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Hagerstown Md. Date signed: 10/25/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Hornbaker 11423 25

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (734)

CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 Years
Hospital, institution, or street address where death occurred:
643 West Washington St
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 643 West Washington St
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME Mrs. Stella Shadrach Saylor

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married

6.(b) Name of husband or wife Edgar R.
6.(c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) November 11 1893

8. AGE: Years	Months	Days	If less than one day
51	11	4	...hrs. ...min.

9. Birthplace Breathedsville Wash. Co. Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own Home
FATHER 12. Name Charles Shadrach
13. Birthplace Clearspring Md.
MOTHER 14. Maiden name Marg. Amanda Stahl
15. Birthplace Clearspring Md.
16. Informant Edgar R. Saylor
Address Hagerstown Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/17/45 (month) (day) (year)
Cemetery or crematory Rest Haven Cemetery
Location Hagerstown Md.
18. Funeral director Andrew K. Coffman
Address Hagerstown Md.
19. Oct. 16 1945 Chas. H. Bowers, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 1945 at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-13- 1945 to 10-14 1945 and that I last saw her alive on 7-30-45 1945

Immediate cause of death Found dead in bed (Frequent ventr. extrasystoles at times - death could have been ventr. fibrillation) — DURATION: Dead several hours when found.

Due to Hypertensive Cardiovascular Disease — DURATION: Not definitely Known

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John N. Hornbaker M.D. M. D. or other
Address 154 W. Washington St. Hagerstown, Md. Date signed 10/15/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-c)

CERTIFICATE OF DEATH

10424

Reg. Dist. No. 382

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown Route 11
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Transient

Hospital, institution, or street address where death occurred:
Dead on Arrival Wash. Co. Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Pennsylvania County: Franklin

City or town: Waynesboro
(If outside city or town limits, write RURAL and give nearest town)

Street No. 307 Fairview Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: World War 1

3.(a) FULL NAME: Harry S. Shindledecker

3.(b) Social Security Number: 182-16-2082

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 13, 1895

8. AGE: Years	Months	Days	If less than one day
50	4	22	hrs. min.

9. Birthplace: Virginia Mills-Adams Co., Pa.
(Town, county, and state)

10. Usual occupation: Machinest

11. Industry or business: Waynesboro Nipple Works

FATHER 12. Name: David Shindledecker

13. Birthplace: Fairfield, Pa.

MOTHER 14. Maiden name: Annie Kint

15. Birthplace: Fairfield, Pa.

16. Informant: Mrs. Annie K. Shindledecker

Address: 307 Fairview Ave-Waynesboro, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 9, 1945 (month) (day) (year)

Cemetery or crematory: Fairfield Union Cemetery

Location: Fairfield, Pa.

18. Funeral director: Walter Y. Grove

Address: Waynesboro, Pa.

19. October 8 1945 (Date rec'd by registrar) Elizabeth H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 5, 1945 at 8:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Closed fracture of skull	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: No

Date of op.

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 10/5/45

Where did injury occur? Near Hagerstown (City or town) Wash. (County) Md. (State)

Route #11

Injured at home, farm, industry, public place (where?): Highway

Means of injury: Struck by auto Injured at work? No

23. SIGNATURE: DEPUTY MEDICAL EXAM. J. Robert Wells WASH. CO., MD. M. D. or other

Address: Hagerstown Md. Date signed: Oct 8/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

Dr. Kohler 10425 10

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:

County: washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 years

Hospital, institution, or street address where death occurred:
Chewsville Pike

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. Chewsville Pike
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Mrs. Ellen Amanda Staats

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married

6.(b) Name of husband or wife: Walter A

6.(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.): April 29 1871

8. AGE: Years	Months	Days	If less than one day
74	5	6	....hrs. ....min.

9. Birthplace: North Argyle Wash. Co. N.Y.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER — 12. Name: John Blake

FATHER — 13. Birthplace: Greenwich N.Y.

MOTHER — 14. Maiden name: sarah McCarthy

MOTHER — 15. Birthplace: Greenwich N.Y.

16. Informant: walter A. Staats

Address: Hagerstown Md. R.F.D?

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/8/45 (month) (day) (year)

Cemetery or crematory: Rset Haven Cemetery

Location: Hagerstown Md.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md.

19. October 8 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 5 1945 at 9.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 25 1945 to Oct 5 1945 and that I last saw h... alive on Oct 5 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	10 days
Due to Arterio-Sclerosis	5 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ....Date of.....

Where did injury occur? ....(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: ....Injured at work?

23. SIGNATURE: H. C. Kohler M. D. or other

Address: Hagerstown Md. Date signed 10/6/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Dr. Wells 26

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1day

Hospital, institution, or street address where death occurred: 418 McDowell Ave

How long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 418 McDowell Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: NO

3.(a) FULL NAME: Mrs Susan Yvonne Taylor

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John W.

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): Feby, 10, 1897

8. AGE: Years	Months	Days	If less than one day
48	8	6	....hrs. ....min.

9. Birthplace: New York City, New York (Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business: Own Home

FATHER

12. Name: John W. Penser

13. Birthplace: New York City.

MOTHER

14. Maiden name: Elizabert Brown

15. Birthplace: New York City

18. Informant: John W. Taylor

Address: Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 19/45 (month) (day) (year)

Cemetery or crematory: Four Mile Run Cemetery

Location: Youngstown Ohio

18. Funeral director: Andrew K. Coffman

Address: Hagerstown, Md.

19. Oct. 16 19 45 (Date rec'd by registrar) Ghas H. Howard, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 16 19 45, at 1A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ....19...., to ....19....

and that I last saw h....alive on ....19....

Immediate cause of death	DURATION
Coronary heart disease	4mo
Due to (arteriosclerotic)	
Due to acute coronary occlusion	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: NO ....Date of op....

Autopsy results: NO

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of ....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury ....injured at work?

23. SIGNATURE: S. Robert Wells DEPUTY MEDICAL EXAM. WASH. CO., MD. M. D.

Address: Hagerstown, Md. Date signed: Oct. 16/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

Dr. Knisley

16427

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Years
Hospital, institution, or street address where death occurred:
25 North Locust St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 25 North Locust St.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Miss Carrie Melissa Toms

3.(b) Social Security Number: 214-09-4851

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 7 1883

8. AGE: Years	Months	Days	If less than one day
62	8	5	hrs. min.

9. Birthplace: Euclid Fredrick Co. Md.
(Town, county, and state)

10. Usual occupation: Starcher

11. Industry or business: Troy Laundary

FATHER
12. Name: William E. Toms
13. Birthplace: Euclid Md.

MOTHER
14. Maiden name: Hannah Buhrman
15. Birthplace: Euclid Md.

16. Informant: Delmar Toms
Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/15/45 (month) (day) (year)
Cemetery or crematory: Rose Hill
Location: Hagerstown, Md.

18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.

19. October 15 1945 (Date rec'd by registrar) Chas H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 12 1945 at 3:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 2, 1944 to Oct. 12 1945 and that I last saw her alive on August 1945

Immediate cause of death	DURATION
Coronary occlusion	20 mins.
Due to: Coronary sclerosis	Indef.
Other conditions: Chronic myocarditis with vascular hypertension	Indef.
Other conditions: Chronic nephritis	Indef.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: B. K. Knisley M.D. M. D. or Other
Address: 148 W. Washington St. Date signed: 10/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1218)

10428

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 days
Hospital, institution, or street address where death occurred:
Washington Co. Hospital
How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hancock
(If outside city or town limits, write RURAL and give nearest town)
Street No.: —
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: Mary Minerva Ward Unger

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Raymond Unger SP(X)2f
6.(c) If alive, give age: 27 years

7. Birth date of deceased (mo., day, yr.): Dec. 16, 1917

8. AGE: Years	Months	Days	If less than one day
27	10	3	..... hrs. ..... min.

9. Birthplace: Hancock, Washington Co., Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: —

FATHER
12. Name: William H. Ward
13. Birthplace: Fulton Co., Penna.

MOTHER
14. Maiden name: Goldie Stoner
15. Birthplace: Fulton Co., Penna.

16. Informant: William H. Ward
Address: Hancock, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 21, 1945 (month) (day) (year)
Cemetery or crematory: Berkeley Springs
Location: Berkeley Springs, W. Va.

18. Funeral director: Charles R. Bast
Address: Hancock, Md.

19. Oct 20, 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 19 1945 at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 14 1945 to Oct 19 1945
and that I last saw h-er alive on Oct. 19 1945

Immediate cause of death	DURATION
Toxemia	
Due to Lues disease following congenital	
Due to jaundice	
Other conditions Uremia	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: J. M. Seymour M.D. M. D. or other
Address: Hagerstown Md Date signed 10-20-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15

10429 22

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 30-2

1. PLACE OF DEATH:

County Washington

City or town Hagerstown (WITHIN CORPORATE LIMITS)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 years

Hospital, Institution, or street address where death occurred:

Wash. County Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown (WITHIN CORPORATE LIMITS)

(If outside city or town limits, write RURAL and give nearest town)

Street No. 657 Potomac Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Robert Randolph Verdier

3.(b) Social Security Number 214-09-2107

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Ida Verdier

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 28, 1901

8. AGE: Years	Months	Days	If less than one day
43	9	12	..... hrs. ..... min.

9. Birthplace Mt. Alto- Franklin Co. Pa.
(Town, county, and state)

10. Usual occupation Embalmer

11. Industry or business

FATHER 12. Name Benjamin Verdier

13. Birthplace Franklin County Pa.

MOTHER 14. Maiden name Myrtle Freeze

15. Birthplace Franklin Co., Pa.

16. Informant Mrs. Ida Verdier

Address 657 Potomac Ave. Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 13, 1945 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Md.

18. Funeral director Fred W. Kraiss

Address Hagerstown, Md.

19. Oct 13, 1945 (Date rec'd by registrar) Chas. H. Rowe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10, 1945 at P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
coronary heart disease (arteriosclerosis)	1yr
Due to	
Due to acute coronary occlusion	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Robert Lewis DEPUTY MEDICAL EXAM. WASH. CO., MD. M. D. or

Address Hagerstown, Md. Date signed 10/10/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for the change of age is shown on

FILE No. G 98 OCT 19 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 303

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Washington County
City or town: Hagerstown Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Downsville Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. Downsville Maryland
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Letha Waffensmith

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John Waffensmith
6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Aug. 16 1883

8. AGE: Years	Months	Days	If less than one day
62	1	21	hrs. min.

9. Birthplace: Montgomery County Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Housewife

FATHER
12. Name: George Roberts
13. Birthplace: Montgomery Co. Md.

MOTHER
14. Maiden name: Hannah Weddle
15. Birthplace: Montgomery Co. Md.

16. Informant: John Waffensmith
Address: Downsville Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 10 1945 (month) (day) (year)
Cemetery or crematory: Manor Cemetery
Location: Tilgmanton District

18. Funeral director: Edith V. Leaf
Address: #7 Church St. Williamsport, Md.

19. Oct. 10. 19 45 (Date rec'd by registrar) Elizabeth Boward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/7/45 19 at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/4/45 19 to 10/7/45 19 and that I last saw h.. alive on 10/7/45 19

Immediate cause of death	DURATION
Coronary Occlusion	10 HRS.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: strangulated umbilical Hernia Date of op. 10/4/45

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: C. F. Gowen M. D. or other
Address: Williamsport, Md. Date signed: 10/9/45

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-A)

Dr. Bell 10431

CERTIFICATE OF DEATH

Reg. Diat. No. 38 2

1. PLACE OF DEATH:
County: Washington
City or town: Near Bridgeport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 31 Years
Hospital, Institution, or street address where death occurred:
Cavetown Pike
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Bridgeport
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Cavetown Pike
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Miss Mary Helen Wolfinger

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife: None
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 30 1876

8. AGE: Years	Months	Days	If less than one day
~~69~~ 69	4	28	hrs. min.

9. Birthplace: Chewsville Washington Co Md.
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Own Home
FATHER 12. Name: Alex. M. Wolfinger
13. Birthplace: Leitersburg Md.
MOTHER 14. Maiden name: Sophie J Lambert
15. Birthplace: Leiterburg Md.
16. Informant: Mr Marshall A. Wolfinger
Address: Hagerstown, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/31/45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown Md.
18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.
19. Oct. 30 1945 (Date rec'd by registrar) Chas. H. Beavers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 28 19 45, at 10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 19 28 to Oct. 28, 19 45
and that I last saw h.er alive on October 1, 19 45

Immediate cause of death	DURATION
Chronic cardiovascular-renal disease,	10 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: No operation
Date of op.:
Autopsy results: No autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. A. Bell M. D. or other
Address: Hagerstown Md. Date signed: 10/29/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

10432

CERTIFICATE OF DEATH

★ Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Rural Hagerstown, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 years

Hospital, institution, or street address where death occurred: Hagerstown Route #2

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Route #2, Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Broadfording Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: James Franklin Wollard

3.(b) Social Security Number: 705-10-7736

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Daisy Wollard

6.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): October 28, 1902

8. AGE: Years	Months	Days	If less than one day
42	11	15	..... hrs. ..... min.

9. Birthplace: Thurmont, Maryland (Town, county, and state)

10. Usual occupation: R.R. Engineer

11. Industry or business: W.M.R.Road

FATHER — 12. Name: Frank W. Wollard

13. Birthplace: Thurmont, Maryland

MOTHER — 14. Maiden name: Maud Davis

15. Birthplace: Thurmont, Maryland

18. Informant: Mrs. James F. Wollard

Address: Hagerstown Route #2

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-16-45 (month) (day) (year)

Cemetery or crematory: Rest Haven Cemetery

Location: Hagerstown, Maryland

18. Funeral director: C. M. Suter & Sons

Address: Hagerstown, Maryland

19. October 15 19 45 (Date rec'd by registrar) Chas. H. Coovert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 13, 1945, at 9 A.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Oct 13 1945 to Oct 13 1945 and that I last saw h alive on Oct 13 1945

Immediate cause of death	DURATION
(a) Uremia	2 days
Due to	
Due to	
Other conditions: Hypertension, Cerebro Vascular Disease	5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: D. L. Beachley M.D. or other

Address: Hagerstown, Md. Date signed: Oct 15 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr. Kneisley

10433

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 502

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, institution, or street address where death occurred:
636 Potomac Ave
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 636 Potomac Ave
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME: Mrs. Virginia Ditto Wyand

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife O. Judd

6.(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) February 6 1888

8. AGE: Years	Months	Days	If less than one day
57	7	29	hrs. min.

9. Birthplace Park Head Wash. Co. Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER
12. Name Abraham Ditto
13. Birthplace Warfordsburg Pa.

MOTHER
14. Maiden name Elizabeth Oliver
15. Birthplace Hancock Md.

16. Informant O. Judd Wyand
Address Hagerstown ¾ Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/8/45 (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Hagerstown Md.

18. Funeral director Andrew K. Coffman
Address Hagerstown Md.

19. October 8 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5 1945 at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 20, 1945 to 10/5/45
and that I last saw her alive on October 5, 1945

	DURATION
Immediate cause of death: Gastric Hemorrhage	3 hrs.
Due to: Carcinoma of liver	Indef.
Due to: Carcinoma of gall-bladder	Indef.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of liver and gall-bladder. By Dr. Wroth Date of op. 3/8/45

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE B B Kneisley M. D. or other
Address 148 W. Washington St., Date signed 10/6/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15